King County

Department of
Community and Human Services

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FINAL PROCUREMENT PLAN
Veterans and Human Services Levy: 3.1
Increasing Access to Behavioral Health Services Available through Community Health Centers, Public Health Centers, and Other Safety Net Clinics

1. Goal (Overarching Investment Strategy)

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of increasing access to mental health and chemical dependency services available through community health centers, public health centers, and other safety net clinics (described on page 22 of the SIP). Mental health and chemical dependency services coordinated by or provided in primary care clinics are collectively termed "integrated behavioral health services".

2. Objective (Specific Investment Strategy)

The Service Improvement Plan recognized that a significant challenge for King County is the lack of access to behavioral health services, especially for individuals who are not eligible for Medicaid and long-term care in the public mental health system. To address the complex needs of target populations, this procurement plan presents strategies to expand evidence-based integrated behavioral health services in King County safety net primary care clinics.

3. Population Focus

The Service Improvement Plan recognizes two targeted populations:

- **Veterans and their families** who are struggling with or at risk of mental illness, substance abuse, homelessness, and associated health problems including post traumatic stress disorder, and
- **Other high risk individuals and families** experiencing difficult life circumstances including homelessness and other unstable housing situations, who are similarly at risk of mental illness, substance abuse and associated health problems.

4. Service Needs and Populations to Be Served

The target populations for this levy investment have many complex and extensive needs in common, including periodic or long term homelessness, extreme poverty, mental illness, and abuse or addiction to drugs and alcohol (see page 11 of the SIP). Both populations tend to be frequent users of King County safety net services, including both primary care and hospital emergency departments.

Veterans, Military Personnel, and Their Families

King County is home to thousands of veterans, military reservists and members of National Guard Units, including those who served in World War II, the Korean and Viet Nam Wars, the Gulf War, and current conflicts in the Middle East.[1] Levy funds are intended to assist those in need who have served at any time in the U.S. military, so as to support veterans and their families to re-integrate into civilian life.

Information about the demographics of veterans and their families can help guide development of this investment:

- In 2004, there were more than 147,000 civilian veterans living in King County.[2] Of this number, 40 percent are Viet Nam veterans and 16 percent are Gulf War veterans.
- Around one third are 65 years or older; seven percent are women.
- It is estimated that as many as 30 percent of homeless persons in King County are veterans.[3]
- There is general agreement among organizations now working with veterans that those returning from more recent Middle East deployments tend to have lower incomes and less education than veterans of previous deployments.
- 2000 census tract data identified high concentrations of traditionally defined veterans in and around downtown Seattle, Renton, Auburn, Kenmore, Kent and Crossroads areas. Each of these communities had one or more census tracts with a veteran's population numbering 259-628.

Other High-Risk Individuals and Families

The Service Improvement Plan also sets aside funding for services to vulnerable individuals and families who are not generally eligible for publicly funded mental health services, but are experiencing difficult life circumstances. These circumstances include mental illnesses and/or other chronic health conditions, problems with drug use or addiction, periodic or long-term homelessness, poverty, domestic violence or other circumstances that create instability and health risk.

A demographic profile of high-risk individuals served by existing programs informs planning for the Levy investment in integrated behavioral health programs:

- King County's community health centers, public health centers, and other core safety net clinics[4] served 127,258 low-income persons in 2006, including many homeless and high risk individuals and families. Of this total, 40 percent (n = 51,142) were not eligible for Medicaid or other coverage.
    - The majority of uninsured were between 35-59 years (40 percent of uninsured) or 19-34 years (38 percent). The majority of uninsured adults were Latino (34 percent), white (33 percent), or Black / African American or East African (12 percent).

[1] Appendix A of the Service Improvement Plan provides a lengthy explanation of how veterans' discharge status is to be defined for the purposed of qualifying individuals for Levy support services.
[2] 2004 American Community Survey, U.S. Census Bureau
[3] 2004 One Night County of Homeless People
[4] Demographics reported here include clients of Harborview Medical Center's Pioneer Square Clinic, but do not include clients served at Harborview's other primary care sites.

- Demographics of persons enrolled in the state-funded General Assistance-Unemployable (GA-U) program should also be considered in developing this Levy investment as King County's GA-U population includes many persons who might otherwise be supported by this Levy investment:
    - GA-U eligibility is restricted to low income people who are physically and/or mentally incapacitated and unemployable for more than 90 days.
    - Many GA-U clients are part of the target populations: challenged by poverty, physical illness, mental health and substance abuse issues, and lack of housing.
    - King County is home to approximately 2,500 individuals who may be eligible for time-limited GA-U benefits.[5]
    - State data show that around 45 percent of this population has an identified mental health issue.[6]
- The health department's Health Care for the Homeless Network (HCHN) contracts with community agencies to improve access and provide services for homeless and formerly homeless people. Services are provided in shelters, day centers, supportive housing facilities, and health centers. In 2006, a total of 21,438 persons were served by HCHN contractors and public health centers.
    - Of this total, 57 percent of those served were people of color and 43 percent had no insurance coverage. Homeless people served were African American (23 percent), Hispanic or Latino (16 percent), Asian/Pacific Islander (7 percent), American Indian/Alaska Native (5 percent) or multiracial (5 percent).
    - Of all those served outside of primary care settings, 31 percent had at least one mental health diagnosis and/or chemical dependency diagnosis.

Need for Integrated Behavioral Health Services

The Levy Strategic Improvement Plan (SIP) recognized that a significant challenge for King County is the lack of access to behavioral health services, especially for individuals who are not eligible for Medicaid and long-term care in the public mental health system (page 22 of SIP).

- Regional Support Network (RSN) community mental health agencies can offer limited to no access to outpatient mental health services for those who do not qualify for Medicaid. Only those persons with the most severely debilitating mental illnesses are able to qualify.
- There are no state and severely limited federal funding mechanisms to support the provision of behavioral health services in federally qualified health centers, including both community and public health centers.

Needs of Veterans, Military Personnel, and their Families

Using government data sources, a recent working paper from Harvard University's John F. Kennedy School of Government analyzed the long-term needs and costs of veterans returning from the Iraq and Afghanistan conflicts, and found the largest unmet need to be mental health

[5] Verbal communication with Betsy Jones, Community Health Plan consultant to GA-U Pilot, August 2007.
[6] Bennett, Amandalei. "GA-U Managed Care Pilot: Report to the Legislature." Health and Recovery Services Administration, Division of Program Support Office of Care Coordination. Washington State DSHS, January 2006.

care.[7] The author notes: "The strain of extended deployment, the stop-loss policy, stressful ground warfare, and uncertainly regarding discharge and leave has taken an especially high toll on soldiers."

Needs of families shift dramatically depending on where the service member is in the cycle of deployment:

- In the pre-deployment stage, the service members' workload and stressors are tripled, and service members and families often experience discord, anger, and emotional detachment.[8]
- For families, deployment is exceedingly stressful, characterized by depression, anxiety, and sleep disturbance among other stress-related health problems.[9]
- Post-deployment presents the challenge of reintegration into family and civilian life, and service members' mental health symptoms often increase between the time of homecoming and three to four months post-deployment.[10] For families, dealing with the returning family member's severe mental and behavioral health conditions can be exceedingly stressful.
- Children's responses to deployment are varied and depend on age, as well as family and individual factors, but can include sadness, changes in eating habits, and decline in school performance.
- When mothers are the deployed parent, children also experienced problems in peer relationships, emotional expression, learning, and physical health. Families with returning service members who are experiencing PTSD and combat-related stress may also be at increased risk for child abuse.[11]

During deployment, a substantial proportion of service members experience significant traumatic events, the impact of which are magnified by the harsh living conditions of combat: Seventeen percent of soldiers serving in Iraq in 2006 suffered from acute stress, depression, or anxiety according to an Army survey, and rates were higher among soldiers who had at least one prior deployment (18 percent), a situation increasingly common in the current war.[12]

The Harvard working paper estimates that 36 percent of veterans treated thus far - an unprecedented proportion –have sought help and been diagnosed with behavioral health conditions including PTSD, acute depression, substance abuse and other conditions. There are no reliable data on VA waiting lists for medical and behavioral healthcare, but even the

[7] Bilmes, L. "Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits." Faculty Research Working Papers, Harvard University JFK School of Government RWP07-001, January 2007.
[8] "The Psychological needs of the U.S. Military Service Members and Their Families: A Preliminary Report." American Psychological Association Task Force on Military Deployment Services for Youth, Families, and Service Members, February 2007. Available at http://www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.

VA conceded in a recent editorial that the lists are so long as to effectively deny treatment to some veterans.[13]

Among the most prevalent injuries associated with the current military operation is traumatic brain injury (TBI) related to blast injuries. In 2005, 22 percent of all wounded had a TBI, which is frequently accompanied by cyclical depression, psychomotor coordination problems, hearing loss, affective instability, memory problems, and trouble concentrating.[14]

The trauma of war is frequently compounded for service members by the trauma of sexual violence. A 2003 Veteran's Administration report indicated that, across National Guard and Reserve components, the estimated prevalence of any military sexual trauma (MST) during active duty is 60 percent among females and 27 percent among males. MST includes sexual harassment, sexual assault and rape. The estimated prevalence for rape among females is 11 percent and among males is 1.2 percent.[15] Exposure to military sexual violence increases the risk of domestic violence upon the service members' return.[16]

Other High-Risk Individuals and Families: Nationwide, mental health issues and substance abuse together constitute the leading reason for a visit to a health center.[17] Patients identified in a primary care setting as needing behavioral health services include those with emotional distress, mood disturbance, as well as chronic and complicated physical health diagnoses. These patients, including veterans and other high-risk individuals, frequently have significant co-morbidities, and are diagnosed with mental health disorders and serious chronic physical health conditions such as diabetes or hypertension. Providing care to these patients consumes significant King County health resources in primary care, inpatient settings, and emergency departments.

A recent evaluation of a sample of local health center 2006 claims data suggest that 18,000 to 38,000 diverse, low-income adults served by King County health centers are in need of mental health and chemical dependency services.[18] Of this number, around 40 percent (7,200 to 15,200) are not eligible for Medicaid or other publicly sponsored coverage. Between 12 and 17 percent of patients were diagnosed with a chemical dependency or mental health condition.

This is likely a significant underestimate of the prevalence of these conditions, as providers frequently tend to underutilize mental health and chemical dependency diagnostic codes unless there is reimbursement connected to these services. In a recent analysis of Colorado

[13] Murphy, F. *Psychiatric News,* May 2006.
[14] ibid
[15] "Military Sexual Trauma Among the Reserve Components of the Armed Forces." The Veterans Milennium Health Care and Benefits Act. October 2003. Available at http://veterans.house.gov/democratic/press/109th/pdf/mstreport.pdf
[16] Ibid.
[17] 2003 Uniform Data System, cited in "Health Centers' Role in Addressing The Behavioral Health Needs of Medically Underserved." September 2004 Issue Brief from National Assoc. of Community Health Centers
[18] 2006 claims data used in developing this estimate were made available from Community Health Centers of King County and Public Health Seattle & King County.

claims data for adult Medicaid managed care enrollees, where state reimbursements are available to qualified health centers, 39 percent had a psychiatric diagnosis.[19]

5. Funds Available

The Service Improvement Plan (SIP) establishes funding levels for targeted populations as follows:

Levy Funds Available by Year		
	2007 Funds	Annualized, 2008-2011
Veterans Levy	$600,000	$800,000
Human Services Levy	$500,000	$500,000

The SIP proposed $800,000 annually to support services targeting veterans and their families in need. In addition, this procurement plan proposes that $600,000 in 2007 funds will be carried forward and divided over the remaining four years of the Levy, adding $150,000 annually.

The SIP proposed $500,000 annually to support services targeting other high-risk individuals and families experiencing difficult life circumstances. In addition, this plan proposes that $500,000 in 2007 funds will be carried forward and divided over the remaining four years of the Levy, adding $125,000 annually.

This procurement plan proposes that total Levy funding for each year, 2008 through 2011, total $1,575,000, to be budgeted as in the following table:

Total Levy Funds Proposed, 2008-2011	
	Annualized Funds + 2007 Carry-Forward
Veterans Levy	$950,000
Human Services Levy	$625,000
Annual Funding, 2008-2011	**$1,575,000**

6. Program Description

Conceptual Framework: The proposed program design for this Levy investment is based on established models already widely in use by King County safety net agencies:

- The "four quadrant" integration model articulates appropriate roles, competencies and tools for clinicians and providers across primary care and in the mental health system.[20] This framework provides guidelines and organizing principles useful in the implementation of an "ideal" integrated system, based on clients' health risks and symptoms - rather than on the realities of funding streams and other limitations.
- The IMPACT behavioral health model, supported through the University of Washington Department of Psychiatry and Behavioral Sciences, is an evidence-based practice model that helps primary care providers and mental health providers collaborate successfully to

[19] Thomas et al. "Prevalence of Psychiatric Disorders and Costs of Care Among Adult Enrollees in a Medicaid HMO." 2005. *Psychiatric Services* 56:1394-1401.

[20] National Council for Community Behavioral Healthcare. "Behavioral Health / Primary Care Integration. The Four Quadrant Model and Evidence-Based Practice." Winter 2004.

treat depression.[21] The model will become more widely used in King County over the next few years, as Community Health Plan is adapting the IMPACT model in its pilot of a mental health benefit for King County GA-U clients. The pilot is slated to begin in late 2007.

- Key elements of the IMPACT model reflect best practices in integrated behavioral health models, including the following:
  - Behavioral health coordinators or clinicians (BHCs) provide support to primary care providers and their patients in order to address mental health and chemical dependency concerns.
  - Psychiatrists provide consultation to BHCs and primary care providers, but are not involved in direct patient care.
  - Systematic diagnosis is based on the use of standardized screening and clinical assessment tools.
  - All members of the primary care team use evidence-based treatment algorithms.
  - Patient treatment and outcomes are tracked using registries and other information systems to allow for close follow-up.
  - "Stepped care" protocols and guidelines are used to change the plan of treatment depending on patient outcomes.

How Behavioral Health Clinicians Work: The Levy investment in a primary care role for behavioral health care coordinators or clinicians (BHCs) is very different from the role of their colleagues in the mental health treatment system:

- In an integrated model, BHCs provide consultation, support and assistance to primary care providers and their patients in order to address mental health and chemical dependency concerns, but without engaging clients in extended or specialized mental health treatment.
- BHCs are typically Master's prepared social workers or psychologists who function as part of the primary care team, working flexibly to provide both consultation and direct care. Bachelor's prepared nurses may also function in a coordinating role to support the provision of behavioral health care.
- Services provided by BHCs are brief interventions that are time limited. BHCs use a consultative, psychoeducational approach; service modalities include single session strategies, case management, linkage to community programs and other community agencies, and crisis management as needed.
- BHCs are often the link between primary care and more specialized psychiatric consultation, as necessary to meet patients' complex needs. For example, primary care providers are responsible for prescribing all medications, including psychotropic medications, but in more complicated cases, BHCs and providers will consult with a psychiatrist from the mental health system about medications.

Adapting the Model to Meet Veterans' Needs: As previously described, 36 percent of veterans treated nationwide thus far have sought help and been diagnosed with behavioral health conditions including PTSD, acute depression, substance abuse and other conditions. According to the program director for Veterans for America, a leading advocacy group, "The

[21] Information about this practice model is available at http://impact-uw.org/

signature wounds from the wars will be (1) traumatic brain injury, (2) PTSD, (3) amputations and (4) spinal chord injuries, and PTSD will be the most controversial and most expensive."[22]

Long-term manifestations of PTSD and other chronic health concerns suggest that a significant portion of returning veterans and their families, including Reservists and National Guard, will be at high risk for loss of housing, income and employment, and family and social support. However, there is as yet little information with which to predict where veterans returning from current and future Middle East deployments will settle in King County (these concerns are further explored in Section 10).

In consideration of these unknown factors, the procurement plan proposes three overall strategies to allow some flexibility for pilot programs and to build a better understanding of King County service gaps for veterans and their families.

Strategy 1:

Provide funding to support implementation of clinic data systems that can track veterans' status, PTSD screening, and the service utilization of veterans and their families. Health center contractors will need technical assistance in developing standardized tracking of veterans' status, benefits eligibility, coverage and service utilization. Time-limited assistance will be provided either by Public Health staff or through an external contractor. This information will allow both health centers and the King County Veteran's Program to learn more about where veterans and their families are already seeking care and help us to assess what services are most needed. Levy funds could then be targeted to support veterans in their existing primary care homes, building upon the existing trust relationships between veteran and primary care provider.

Strategy 2:

Pilot some service delivery locations and strategies on a small scale, so as to assure that services are available countywide and build a better understanding of service gaps for veterans. This strategy will provide funding for one- or two-year pilot strategies that improve geographic access to medical and behavioral health interventions, particularly in suburban cities. Pilots will be coordinated with the service expansion to new communities supported by the King County Veteran's Program. Based on the outcomes of pilot programs, coupled with more data about returning veterans' residence and family needs, a number of the successful pilot programs could be enhanced in the last two to three years of the Levy if other pilots are not continued.

Strategy 3:

Provide funding to support two or more clinic-based programs that will build or greatly enhance resources and special expertise in PTSD treatment and other concerns of veterans. Clinics selected would receive adequate Levy resources with which to create staff positions and specific expertise in PTSD management, and be able to offer intensive behavioral health support in a comprehensive medical home model for veterans and their families. These services would be close to home, close to other social services, and

[22] Sullivan, P. Program Director of Veterans for America, 12/23/06 interview with L. Bilmes (reference 7).

efficiently aligned with other existing sources of care and social service programs for veterans.

7. Evidence-Based Practice and Cost Savings

The proposed model is based on evidence-based strategies and proven practices that have been shown in numerous studies and evaluations to improve clinical outcomes. Also important to Levy goals, behavioral health models achieve savings in overall health costs. Similar programs have demonstrated improved outcomes and cost savings:

- Gilbody's 2006 cumulative meta-analysis of integrated care in 37 trials found that this treatment model is more effective than standard care in improving depression, in both the short and longer term.[23]
- A 2006 study completed for the Washington State Legislature determined that mental health treatment for General Assistance-Unemployable (GA-U) clients with mental illness significantly reduced medical costs, as compared to GA-U clients who remained untreated.[24] Medical costs were reduced by $174 to $255 per member per month in the first year.
- The Buncombe County, North Carolina, public health clinic demonstrated improved access to mental health services and reduced overall costs for clients with clinical depression. An external evaluation found increases in mental functioning, including reductions in the number of days of work or school missed and increases in the number of depression-free days reported by clients. In addition, overall health care cost reductions of $66 per patient per month were achieved.[25]

8. Coordination, Partnerships, and Alignment Across Systems

The health department has consulted with numerous parties, including health centers and other safety net clinics, suburban planners, DCHS program staff, and others, in framing this procurement plan. The proposed service strategy requires close coordination and partnership with numerous programs, including other Levy funded programs that serve similar and sometimes overlapping target populations:

- DCHS Mental Health, Chemical Abuse and Dependency Services Division (MHCADS) administers state funding for the Regional Support Network (RSN), funds which are contracted to numerous community mental health agencies. Health centers will need to strengthen working relationships with RSN agencies and may elect to contract with RSN agencies to provide behavioral health staffing, psychiatric back-up and other consultation to primary care teams. The goal is to increase the availability of integrated / linked mental health services across a wider continuum of care – not to build a "parallel" system in health centers.
- DCHS King County Veteran's Program (KCVP) is responsible for many aspects of expanding Levy social services to Veterans and their families. Health centers and clinics

[23] Gilbody, S, et al. "Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer Term Outcomes." Archives of Internal Medicine. 2006; 166:2314-2321.

[24] Mancuso, D and Estee, S. "Washington State Mental Health Services Cost Offsets and Client Outcomes Technical Report." Washington State DSHS Management Services Administration, Research and Data Analysis Division. December 2003.

[25] Mims, SJ Public Health Management Practice. 2006, 12(5), 456-461.

will need to link to and partner with KCVP and their local contracting agencies, as well as other programs and services targeting traditionally defined veterans.

- King County's suburban cities, particularly in south King County, will see impacts of expanding KCVP services in their communities.
- DCHS Housing and Community Development (HCD) is beginning competitive processes that will increase the number of housing units available to chronically homeless veterans and other households with intensive service needs.[26] Health centers and clinics may partner with housing providers to create additional supportive services, as this new housing stock becomes available in the next four years.
- Coordination is also needed with the DCHS Levy training initiative to support and expand PTSD screening in primary care. Screening activities will need to be linked to follow-up assessment where indicated, with coordinated treatment referrals to more specialized services where necessary.
- Beginning in October 2007, Community Health Plan will pilot a mental health benefit for King County's approximately 2,500 GA-U clients, many of which are part of the Levy target populations. Every effort must be made to coordinate these programs and leverage the limited state-funded GA-U benefit where feasible, even though the Washington State Legislature has not provided sufficient funds to meet the needs of all current King County GA-U enrollees.
- A 0.1 percent sales tax increase has been proposed in King County to increase funding for mental health and chemical dependency services. If the proposal is adopted, Levy-supported service strategies will need to dovetail with proposed services.

9. RFP Process for Allocating Funds

The allocation of funds will occur through a competitive Request For Proposals (RFP) process managed by Public Health Seattle & King County. The Community and School-Based Partnerships Program, which oversees other local investments in community health centers, public health centers, and other safety net clinics, will provide oversight, develop the RFP, provide staff support to RFP reviewers, and be responsible for all contracting and technical support functions related to these funds.

To maintain clear accountability on the intent of Levy funds, the RFP will be divided into two investment areas, separately awarding the two funding streams provided for two targeted populations. However, as considerable service overlaps may exist in behavioral health programs that serve safety net populations, health centers and clinics may elect to apply for funding in one or both investment areas and propose a combined budget model. For example, a health center that serves a large number of homeless persons, of which around half are veterans, might proposed a full-time position jointly funded by each investment area.

Proposed annual funding available for direct services to veterans and families is $750,000 (see budget breakdown in following Table 1). For year 1 (2008), funding for veterans and their families will be further divided into two RFP levels, in order to build in flexibility to respond to the needs of those returning from current and future deployments**.** Please see the

[26] The approved procurement plan for Levy-supported permanent housing is available on line at: http://www.metrokc.gov/dchs/Levy/ProcurementPlans/HousingServices.pdf

following section for a discussion of why this strategy is proposed and how it will be implemented.

Proposed annual funding available for direct services to high-risk individuals is $500,000 (see budget breakdown in following Table 2). In year 1 (2008), the RFP process will award five or more four-year grants of up to $100,000 annually to support behavioral health services for the target population of high-risk individuals and families.

The competitive RFP process for each investment area will include a written application, site visit and/or interviews with key management responsible for program implementation. An informational session/bidders' conference will be held for prospective applicants to ask questions and receive technical assistance.

Reviewers will include representatives from the Levy Oversight Boards, those with expertise in the implementation and delivery of evidence-based behavioral healthcare, expertise in federally and state funded programs for veterans, and those with experience and expertise in how local safety net primary care services are structured. The review team will be selected so as to also represent diverse backgrounds in culture, language, and specific program expertise.

10. Geographic Coverage: Special Considerations for Veterans Services

There is as yet limited information about where veterans returning from current Middle East deployments will settle in King County. Information is now being collected from numerous sources, and will include information about the residency of National Guard families and other Reservists, as well as Army veterans. It is widely assumed that these families tend to have lower incomes and less education than veterans of previous wars, suggesting that they will tend to reside in more affordable communities. Information about residency will need to be taken into account in targeting funding to priority geographic areas in King County.

Coordination with countywide expansion of King County Veteran's Program (KCVP) services is an important consideration in determining the best clinic sites for behavioral health programs funded by the veteran's portion of the Levy. Primary care clinics may wish to partner with service agencies that are providing expanded KCVP services, and/ or state or federally funded veterans services, in developing proposals for Levy funding.

To manage geographic "unknowns" and build in flexibility to respond to the needs of those returning from current and future deployments, the plan proposes two levels of awards for 2008:

- Up to $450,000 will be awarded for two or more significant, multi-year grants ($100,000+ annually) to health care organizations that are already serving this target population and propose to develop a significant commitment and specific expertise in responding to the needs of veterans and their families.
- Around $300,000 will be awarded for one- and two-year pilot projects of smaller scope (up to $75,000 annually). These funds will provide some flexibility in the first two years to pilot different strategies and build a better understanding of needs and gaps in services

for veterans. At the end of this period, funds may be reallocated to expand a smaller number of successful pilots for the remainder of the current four-year Levy.

11. Program Indirects, Administration, Technical Assistance and Evaluation

The health department's role in personal health care provision is to help assure access to high quality health care for all populations. This role includes a significant in-kind commitment of staff time and resources to guide and support implementation of this Levy investment in numerous clinics and communities; guide and provide support for mid-course corrections; and provide systems for data collection and reporting that will be used to produce summary evaluative reports.

In total, the Levy investment in program indirects and administration will support:

- Salary, benefits (33 percent of salaries), and associated costs for 0.25 FTE of Community & School-Based Partnership program manager
- Funding for anticipated technical assistance needs through contracts:
    - Training and technical assistance in program implementation and performance measurement;
    - Database development tracking system for contractors' services to veterans; and
    - Funding for external program evaluation reports on clinical outcomes and cost offsets.
- Public health indirect costs at 7.69 percent of total funding.

Table 1: Integrated, Behavioral Health Services
Proposed Investment for Veterans & Families, 2008-2011

Proposed Investment Areas: **Veterans & Families** Integrated behavioral health services targeting veterans and their families who are struggling with or at risk of mental illness, substance abuse, homelessness, and associated health problems including PTSD	**Annual Funding, 2008-2011**
Four-year contracts awarded to two or more safety net organizations, partnerships, or consortiums (Between $100,000 and $225,000 annually) to develop significant resources, commitment and specific expertise in responding to the needs of veterans and their families • Depending on quality and scope of applications, RFP reviewers may reallocate funds to smaller scope projects (described below)	$450,000 (47.37%)
One- and two-year contracts awarded to three or more safety net organizations for projects of smaller scope (up to $75,000 annually), with the intent of providing flexibility for innovation and countywide access, and building a better understanding of needs and service gaps for veterans. • Proposals to pilot culturally specific strategies to address the needs of a targeted population will be strongly encouraged. • Contracts will be renewed, expanded or allowed to lapse depending on outcomes and performance	$300,000 (31.58%)
Health department costs for **administration, training and technical assistance:** • Salaries, benefits and other administrative costs of supporting 0.15 FTE public health program manager ($20,000) • Set aside for external contract(s) for training and technical assistance ($106,945) to address: o Implementation of clinic data systems to track veterans' status, benefits eligibility, and service utilization o Needs assessment for veterans returning from current and future Middle East deployments • Contractors to have input into determining priorities for training/TA	$126,945 (13.36%)
Health department **indirect costs**	$73,055 (7.69%)
Proposed Total Annual Funding	**$950,000**

Table 2: Integrated, Behavioral Health Services
Proposed Investment for High Risk Individuals & Families, 2008-2011

Proposed Investment Areas: **<u>High Risk Individuals & Families</u>** Integrated behavioral health services targeting high risk individuals and families experiencing difficult life circumstances including homelessness, mental illness, substance abuse, and associated health problems	**Annual Funding, 2008-2011**
Four-year contracts awarded to five or more safety net organizations, partnerships or consortiums to enhance resources and expertise in responding to the needs of high risk individuals and their families	$500,000 (77.11%)
Health department costs for **administration, training, and technical assistance:** • Salaries, benefits and other administrative costs of supporting 0.10 FTE public health program manager ($12,931) • Contract(s) for training, technical assistance, and external program evaluation ($64,000) o Training and consultation from UW School of Medicine Psychiatry and Behavioral Sciences under consideration o Contractors to have input into determining priorities for training/TA and consultation	$ 76,931 (12.31%)
Health department indirect costs	$48,069 (7.69%)
Proposed Total Annual Funding	**$625,000**

12. Timeline

Table 3 below describes the anticipated timeline for program start-up and implementation.

Table 3: Timeline for First Year Activities

First Year Activity	2007 **Q4**	2008 **Q1**	2008 **Q2**	2008 **Q3**
Final review and approval of procurement plan by Levy Oversight Boards	X			
Release of RFP for Integrated Behavioral Health Services		X		
Complete review of proposals and final selection of programs		X		
Negotiation and complete contracts			X	
Program hiring and start-up by successful applicants			X	
Programs at full capacity				X

13. Leveraging Resources

GA-U Mental Health Pilot funds: The Washington State Legislature directed $1,688,000 in state fiscal years 2008 and 2009 to incorporate mental health services into its coverage for King and Pierce County GA-U clients. Approximate 75% of these funds will support integrated behavioral health services for King County GA-U clients. The GA-U population and Levy target populations have significant overlaps that were previously described; some health centers and clinics may be able to leverage their GA-U funding to support Levy target populations.

Medicaid Administrative matching funds: Though difficult to estimate, a significant portion of the costs of Public Health staff time to support the planning and implementation of this program are eligible to receive matching federal funds. Medicaid match revenues will be retained in the administrative budget and used to cover expenditures for program management, technical assistance, and program evaluation.

Other leveraging and in-kind support: The RFP will examine how applicants for funding might propose to leverage additional federal, state, local government and private foundation support. In addition, some health centers have been able to enhance behavioral health resources by incorporating professional internships and psychiatric rotations, in collaboration with the University of Washington.

14. Disproportionality in Access to Behavioral Health

Unmet behavioral health needs are especially great among racial and ethnic minorities. The 2001 report of the Surgeon General found that, compared to other groups nationwide, and despite having similar rates of mental illness over all more frequent mental health diagnoses, minorities are less likely to receive needed care or are more likely to receive poorer quality care.[27] Some examples of disparities cited include:

- The percentage of African Americans receiving care is only half that of non-Hispanic whites.
- Among Hispanic/Latino Americans with a mental health concern, fewer than 1 in 11 contact a mental health specialist for care.
- A large study of Asian Americans/Pacific Islanders found that only 17 percent of those experiencing mental health problems sought care.

15. Disproportionality Reduction Strategy

Barriers to behavioral health care are complex and include a lack of available providers and services, as well as issues of language, culture, and stigma. Stigma surrounding mental health services may prevent individuals from seeking care, and has been well documented in studies among older persons and minorities.[28] Mental health is not an issue that is easy to discuss for immigrant and refugee families; in many cultures, therapy is a foreign concept. In some cultures, manifestation of mental illness often occurs through psychosomatic symptoms and diagnosis is more likely to be delayed if not missed entirely.

[27] USPHS Office of the Surgeon General (2001). "Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General." Rockville, MD.
[28] Ibid.

The most effective mental health interventions begin within the cultural definitions of people being served, and applicants in the RFP process will be asked to demonstrate partnerships with culturally relevant community-based agencies where appropriate. Too frequently, the provision of culturally competent services has been regarded as an enhancement to a "mainstream" service approach. A significant body of literature has documented that services provided by persons speaking the client's native language and knowledgeable of the customs and belief systems of that culture are far more effective than mainstream services.

16. Cultural Competency

Proposals to pilot culturally specific strategies to address the needs of a targeted population will be strongly encouraged. Every contractor will be required to propose one or more specific contract deliverables that are responsive to the cultural context of the specific family populations they intend to serve.

For example, a health care agency or consortium focusing on services to Hispanic individuals and families might propose and implement a new partnership with a licensed mental health provider that has a track record of cultural and linguistic competency among Hispanic populations. Another example that might be more appropriate for some agencies might be implementation of selected standards and best practices of the National Standards on Culturally and Linguistically Appropriate Services (CLAS).[29] The CLAS standards are primarily directed at health care organizations, but implementation is in partnership with the communities being served.

Successful applicants in the RFP process will demonstrate strong mechanisms to ensure cultural and linguistic competency, an area that is already of foremost concern to King County's core safety net clinics. Health centers and safety net clinics hire many bilingual/bicultural staff and their comprehensive services are well designed to deal with the complexities and challenges of serving diverse populations. Consequently they are uniquely suited to provide and expand their behavioral health services for the high-risk populations identified by the Service Improvement Plan.

17. Dismantling Systemic and Structural Racism

The health department works internally and with its safety net contractors to increase awareness of racism as a core determinant of health through training opportunities. Racial discrimination in health care delivery, financing, and research continues to exist and racial barriers to quality health care manifests in a number of ways including: access to primary care, access to insurance coverage, diagnosis and treatment, and provider decision-making.[30] Some researchers have noted that, in many instances, disparities in diagnosis and treatment do not reflect conscious racial bias, but are a stereotyping response that can occur as a result of time pressures in office visits and providers' need for cognitive multi-tasking.[31]

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[29] Information on CLAS and best practices is available at the following websites:
http://xculture.org/research/downloads/CLAS.pdf
http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3

[30] Nelson, A. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," JAMA August 2002, Vol. 94, No. 8.

[31] Geiger, HJ. "Racial Stereotyping: The Need for Cultural Competence." CMAJ June 2001, Vol. 164, No. 12.

Applicants to the RFP will be asked to describe their agency's strategies in addressing systemic racism through policies and in staff training and support. Aspects of the integrated, behavioral health model also help to address some concerns:

- Providing a significant level of consultative support to primary care providers, through behavioral health clinicians and psychiatric back-up, helps to offset some of the typical pressures in safety net primary care, especially in managing diverse clients challenged by complex health needs.
- The IMPACT practice model requires use of evidence-based decision-making and standardized treatment plan algorithms, well coordinated through the primary care team. This improves clinicians' ability to apply the results of applicable research for minority patients, whenever relevant research exists.
- Behavioral health clinicians have experience working with a range of community agencies and resources, and can link clients to culturally relevant services where useful and appropriate.

18. Improvement in Access to Services

The proposal to pilot a number of service delivery strategies on a smaller scale will assure that services are available to veterans countywide, and will also contribute to a better understanding of needs and service gap**s,** particularly in suburban cities. This strategy will improve geographic access to medical and behavioral health interventions.

19. Outcomes

This Levy investment will support high-risk families by piloting and evaluating strategies to prevent, identify and treat behavioral health concerns among targeted populations. This will be accomplished by providing support for staffing models that increase access to medical, mental health and chemical dependency services for those who lack Medicaid mental health benefits or other coverage options. Community health centers, public health centers and maternal child programs will receive funding to develop programs, in coordination with behavioral health services already offered in many safety net clinics.

Selected contractors will participate in developing measurable outcomes and a data collection plan. Proposed outcomes and performance measures are summarized in Table 4 on the following page.

20. Evaluation

As previously noted, the health department will work with its contractors to collect and report sufficient program data so as to report on process and clinical outcomes, evaluate progress in implementation, make course corrections where necessary, and describe other impacts and aspects of the new Levy investment. The investment strategies to support high-risk families will be evaluated on both process and outcome measures by staff hired in DCHS Community Services Division. The health department will also explore the possibilities of a coordinated evaluation effort with the Community Health Plan's GA-U mental health pilot program, through the University of Washington School of Medicine.

Table 4: Increasing Access to Behavioral Health Services Available through Community Health Centers, Public Health Centers, and Other Safety Net Clinics
Strategies and Outcomes / Performance Measures

Strategies	Outcomes / Performance Measures Reported separately for both target populations
Improve access to screening for depression, PTSD, and other mental health concerns	For both target populations: # (%) Primary care clients screened for depression, mental health, and substance abuse issues during primary care visits # (%) Primary care clients screened for PTSD during primary care visits
Improve physical and mental health status and functioning	Results of periodic screening tools used in primary care: • PHQ-2 • PHQ-9 • GAD-7 (anxiety) • PC-PTSD or PTSD symptom scale Clinical outcomes in key medical diagnoses of clients: • Blood pressure • Blood glucose levels (for clients with diabetes) • Other major diagnoses of target population
Improve primary care capacity to treat mental health issues	# (%) Clients in target population receiving treatment through integrated behavioral health programs Average length of stay in behavioral health treatment and care coordination
Improve insurance coverage and minimize gaps in coverage	# (%) Clients who receive requested GA-U or Medicaid coverage, VA benefits, or other appropriate coverage options
Assure access to services countywide	Demographic profile of clients served in each investment area: • Race / Ethnicity • Residence • Age • Insurance status • US military status • Homeless status